TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
DOCTORS HOSPITAL AT RENAISSANCE

MFDR Tracking Number
M4-17-0180-01

MFDR Date Received
September 26, 2016

Respondent Name
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative
Box Number 54

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Patient was admitted through the urgent room, at the time of service patient provided us with incorrect claim # [claim #] DOI [date of injury]. Precert department was contacted on 04/13/2016 ...was told patient does not have WC benefits anymore due to everything was denied. No mention of patient having another open claim for his DOI [date of injury]. On 04/15/2016 patient contacted DHR and provided correct claim number... Based on this information, we are requesting immediate payment or a response within 14 days..."

Amount in Dispute: $11,883.86

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor had out of network approval to treat the claimant for the disputed dates. However, the requestor did not obtain network preauthorization for the admission. Texas Mutual claim [claim #] is a participant in the Texas Star Network...the requestor should access Complaint Resolution through Coventry Workers' Comp Services."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
April 12, 2016 through April 18, 2016	DRG 863	$11,883.86	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all-applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600, sets out the preauthorization guidelines.
3. 28 Texas Insurance Code Chapter 1305 applicable to Health Care Certified Networks.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes.
   - CAC-197 — Precertification/authorization/notification absent
   - 240 — Preauthorization not obtained

Issues

1. Did the requestor meet the exception outlined in Chapter 1305.006?
2. Did the requestor obtain preauthorization for the inpatient services and is the requestor entitled to reimbursement?

Findings

1. The insurance carrier asserts in their position summary the following, "The requestor had out of network approval to treat the claimant for the disputed dates. However, the requestor did not obtain network preauthorization for the admission. Texas Mutual claim [claim #] is a participant in the Texas Star Network...the requestor should access Complaint Resolution through Coventry Workers' Comp Services."

   The requestor filed this medical fee dispute to the Division asking for resolution pursuant to 28 Texas Administrative Code (TAC) §133.307 titled *MDR of Fee Disputes*. The authority of the Division of Workers' Compensation to resolve matters involving employees enrolled in a certified health care network, is limited to the conditions outlined in the applicable portions of the Texas Insurance Code (TIC), Chapter 1305 and limited application of Texas Labor Code statutes and rules, including 28 Texas Administrative Code §133.307.

   Texas Insurance Code §1305.153 (c) provides "Out-of-network providers who provide care as described by Section 1305.006 shall be reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation."

   Chapter 1305.006 outlines the insurance carrier's liability for out-of-network healthcare and states, "An insurance carrier that establishes or contracts with a network is liable for the following out-of-network health care that is provided to an injured employee:

   (1) emergency care;
   (2) health care provided to an injured employee who does not live within the service area of any network established by the insurance carrier or with which the insurance carrier has a contract; and
   (3) health care provided by an out-of-network provider pursuant to a referral from the injured employee's treating doctor that has been approved by the network pursuant to Section 1305.103.

   Review of the documentation submitted by the requestor finds that the requestor met the exception outlined in Chapter 1305.006 (3). As a result, the insurance carrier's issue raised in the position summary is not supported and the disputed services are under the jurisdiction of the Division of Workers' Compensation and therefore, eligible for medical fee dispute resolution. The disputed services are therefore reviewed pursuant to the applicable rules and guidelines.

2. The insurance carrier denied the disputed services with claim adjustment reason code "CAC-197 — Precertification/authorization/notification absent" and "240 — Preauthorization not obtained."

   The insurance carrier states in pertinent part, "...the requestor did not obtain network preauthorization for the admission."

   The requestor states in pertinent part, "Precert department was contacted on 04/13/2016 ...was told patient does not have WC benefits anymore due to everything was denied."

   Per 28 Texas Administrative Code §134.600(p) (1) "(p) Non-emergency health care requiring preauthorization includes... (1) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay..."

   Pursuant to 28 Texas Administrative Code §134.600(p) (1), the Division finds that preauthorization was required for the disputed services. The requestor submitted insufficient documentation to support that the disputed services were preauthorized, as a result, reimbursement cannot be recommended for the inpatient services rendered on April 12, 2016 through April 18, 2016."

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 18, 2016 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.